DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPL	ETED
		15G313	B. WINC			01/25/	2013
			P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>	19038 MISSISSIPPI ST				
	NORTHWEST INDI				N, IN 46341		(X5)
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	*	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0000							
			Woo	00			
	This visit was fo	r a post certification	W00	00			
		evey to the investigation					
		N00119881 completed on					
	12/14/12.	Noo119881 completed on					
	12/14/12.						
	Complaint #IN0	0119881-Not Corrected.					
	Dates of Survey	: 1/16, 1/17 and 1/25/13					
	Facility number:	000832					
	Provider number						
	AIM number: 10						
	Alivi liullibel. I	00249130					
	Surveyors:						
	•	Madical Surveyor					
	·	Medical Surveyor					
	III/QMRP-Team						
	Paula Chika, Me	dical Surveyor III/QMRP					
	There follows 1 1:	Caianaian alaa madaad					
		ficiencies also reflect					
		accordance with 460 IAC					
	9.						
	•	completed 2/1/13 by Ruth					
	Shackelford, Me	dical Surveyor III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

A. BUILDING	LETED 5/2013
15G313 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE	/2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
ARC OF NORTHWEST INDIANA INC, THE HEBRON, IN 46341	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
	02/24/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet Page 2 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		15G313	B. WIN			01/25/2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			MISSISSIPPI ST	
ARC OF	NORTHWEST INDI	IANA INC. THE			N, IN 46341	
ARC OF NORTHWEST INDIANA INC, THE			TILBINO	, III 4004 I		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	bleeding, or oper	nings are noted staff are			complete body check. The	
	to complete an in	ncident report"			administrator was not notified	as
					the origin of this injury was known.	
	Client A's Skin	Assessment sheets from			To ensure future compliance,	
		ndicated the facility staff			wound care procedures have	
		•			been revised for all clients. Ne	w
		it the above mentioned			procedures will take effect in a	
		s right leg on the skin			homes by 2/24/13. Any incide	
	assessment sheets, and/or report the area				in which an injury of unknown	
	to the nurse until	1 1/16/13 when it was		origin occurs will be immediately		
	brought to staff's	attention.			reported to the administrator s	0
					that appropriate protective measure can be implemented	
	The facility's ren	oortable incident reports			and an investigation initiated.	ΔΙΙ
		tions were requested on			investigation are monitored by	
		AM. Interview with the			Quality Assurance director for	
					thoroughness.	
		ator (SC) on 1/17/13 at				
		ated the facility was not				
	able to provide a	ny documentation of				
	reportables and/o	or investigations as their				
	computer system	n was down.				
	Interview with st	taff #1 on 1/16/13 at 5:56				
	PM stated client					
	1	"hitting bed rail with				
	•	dicated facility staff had				
		am on the client's leg.				
	Staff #1 retrieved	d an antibiotic cream and				
	applied to the ab	ove area.				
	Interview with I	PN #1 on 1/17/13 at 3:20				
		A received the area from				
		facility did not report the				
	1 * *	vn source immediately to				
	the administrator	r.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet Page 3 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 01/2	(X3) DATE SURVEY COMPLETED 01/25/2013			
NAME OF P	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST					
ARC OF	NORTHWEST IND	IANA INC, THE	HEBRON, IN 46341					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	9-3-2(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

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Facility ID: 000832

If continuation sheet

Page 4 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		15G313	B. WIN		-	01/25/2013	
ARC OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0227	specific objectives client's needs, as comprehensive as paragraph (c)(3) of Based on observative for (A), the client's if failed to address behavioral need of Findings include During the 1/16/between 5:14 PM group home, clied laying in his bed looking at a prevent A had a quarter stocking at a prevent and ark red circular leg above the and dark red circular area. Five pen pethe dark red circular area. Five pen pethe dark red circular area from leg." Interview with Leg Mindicated should be seen to be	ogram plan states the sencessary to meet the identified by the sesessment required by of this section. ation, interview and reference of the section of the section of the this section. at of 2 sampled clients interdisciplinary team a client's identified of skin picking. at 1 of 2 sampled clients interdisciplinary team a client's identified of skin picking. At 5:55 PM while rious wound area, client is size to half dollar size area on his lower right is size to half dollar size area on his lower right is satisfied. In the middle of the area was a small open oint scabs were around ular area.	W0	227	This client's behavior plan will revised to include skin picking 2/24/13. This is a rare occurrence, but as it detriment to this client's skin integrity, it is be added to his plan. To ensure future compliance, any client thas a behavior that aggravates medical condition will have a team meeting to discuss revisi of the behavior plan. 2/19/13 This client's behavior plan will revised to include skin picking 2/24/13. This is a rare occurrence, but as it is detrimental to this client's skin integrity, it will be added to his plan. To ensure future compliance, staff will report any change in client's behaviors including the that aggravate medical conditi to the Service Coordinator through incident/accident repo or daily logs. The Service will collect data from these source and observation. The Service Coordinator will then hold an interdisciplinary team meeting initiate or revision the current behavior plan to address the emerging behavioral concern.	by al will e nat s a on be by rts	02/24/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet

Page 5 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED				
		15G313	B. WING		01/25/2013			
	PROVIDER OR SUPPLIER		19038	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	1/17/13. LPN # the area from "p indicated client area. LPN #2 st today. Staff info LPN #2 stated "I Interview with S #1 on 1/17/13 at not do that (pick scar." SC #1 inc have a training of the client's picki Client A's record 1/17/13 at 2:35 I Individual Supplebehavior plan di	dervice Coordinator (SC) 2:10 PM stated "He does) unless he has a scab or dicated client A did not objective/plan to address						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet Page 6 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		15G313	B. WIN			01/25/2013	
NAME OF B	DOLUMBER OR GUIRRU IER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			19038 N	MISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE				N, IN 46341			
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
W0252	criteria specified i plan objectives m measurable terms Based on intervie	ccomplishment of the n client individual program ust be documented in s. ew and record review for	Wo	252	Wound care procedures have		02/24/2013
	failed to conduct	lients (A), the facility /document daily skin nts on a client, and/or			been revised for all clients. Ne procedures will take effect in a homes by 2/24/13.To ensure future compliance, the Community Services Nurse ar		
		tioning of the client every				d	
	•	ed in the client's program			Nurse Manager will monitor	iu	
		ed in the chefit's program			wound care sheets for		
	plan.				completion.		
	Findings include	:					
	1/17/13 at 2:35 P Repositioning Ri [Client A] has be osteoporosis, and to these condition pressure ulcers re incontinence. Bacurrently spends awake in his when to be transferred bed to relieve preback/buttocks as muscle movement indicated client A every two hours. The risk plan indichecked and turn	I was reviewed on PM. Client A's 12/12 isk Plan indicated " een diagnosed with, I incontinence, (sic) Due ns [client A] is at risk for elated to immobility and aseline: [Client A] almost all the time he is eelchair or bed. He needs out of his chair and/or essure on his well as to encourage nt." The risk plan A was to be repositioned to a bed, chair or couch. licated client A was to be need every 2 hours at night. itioning Risk Plan also					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet Page 7 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL		
		15G313	B. WING			01/25/	2013	
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	X		19038 N	MISSISSIPPI ST			
	NORTHWEST IND				N, IN 46341			
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		ff should complete a						
	visual inspection	n of [client A's] skin daily						
	and document a	ny changes on the daily						
	logs and wound	care sheetStaff are to						
	notify the Nurse	and Service Coordinator						
		penings, or bleeding is						
	observed"	r						
	observed							
	Client A's Reno	sitioning Tracking sheets						
		cumentation client A was						
	_	ery 2 hours for the						
	following:							
	-1/3/13 12:00 A	M and at 2:00 AM						
	-1/6/13 6:00 PM	I, 8:00 PM and 10:00 PM						
	-1/7/13 12:00 A and 6:00 AM	M, 2:00 AM, 4:00 AM						
	and 6.00 AM							
		M, 2:00 AM, 4:00 AM						
	and 6:00 AM							
	1/10/12 Thorax	was no documentation for						
		om 12:00 AM to 10:00						
	PM.							
	1/14/16/200	A C O O D D C 110 00						
		M, 8:00 PM and 10:00						
	PM							
		Assessment sheets from						
		indicated staff did not						
		document daily skin						
	checks/assessme	ents on 1/7, 1/8, 1/9, 1/13,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet Page 8 of 13

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI 01/2	E SURVEY PLETED 5/2013	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1/14, 1/15 and 1/16/13.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	Interview with staff #2 on 1/16/13 at 5:45 PM indicated facility staff were to document any open areas on the skin assessment sheets. Staff #2 indicated skin assessments/checks were done daily for client A and the completed sheets were sent to the nurse daily. Staff #2 indicated client A was to be repositioned every 2 hours. Interview with LPN #2 on 1/17/13 at 3:20 PM indicated facility staff were to complete daily skin checks on client A and document any areas they found. LPN #2 indicated daily skin assessment sheets were reviewed by the nurse daily. LPN #2 indicated she was covering for the nurse, for the group home, and she did not know where the 1/7, 1/8, 1/9, 1/13, 1/14, 1/15 and 1/16/13 skin assessment sheets were located if completed. When asked what the blanks meant on client A's Repositioning Tracking sheets, LPN #2 stated "They should be filled out." LPN #2 indicated client A was to be repositioned every 2 hours.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet

Page 9 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		15G313	B. WIN			01/25/	2013
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST		
	NORTHWEST INDI		HEBRON, IN 46341				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
W0331	services in accord Based on observing record review for (A), the facility's to ensure staff do body sheet, compakin checks as refailed to ensure face	provide clients with nursing dance with their needs. ation, interview and r 1 of 2 sampled clients a nursing services failed ocumented an injury on a pleted/documented daily ecommended, and/or facility staff followed ons in regard to a client's	W0	331	An incident report will be filled for all new instances of skin breakdown for all clients. New wound documentation procedurill begin at all houses by 2/24/13. To ensure future compliance, the Community Services Nurse and Nurse Manager will monitor wound casheets for completion.	ures	02/24/2013
	Findings include	:					
	between 5:14 PM group home, clie laying in his bed looking at a prev A had a quarter s dark red circular leg above the and dark red circular	16/13 observation period M and 6:20 PM, at the ent A was in his bedroom. At 5:55 PM while rious wound area, client size to half dollar size area on his lower right kle. In the middle of the area was a small open oint scabs were around ular area.					
	PM stated client injury/area from leg." Staff #1 in been putting crea	"hitting bed rail with dicated facility staff had am on the client's leg. d an antibiotic cream and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet

Page 10 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		15G313	B. WIN	IG		01/25/	2013
NAME OF P	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE			HEBRO	N, IN 46341			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		l was reviewed on					
		PM. Client A's 12/12					
		isk Plan indicated					
		complete a visual					
		ient A's] skin daily and					
	document any cl	nanges on the daily logs					
	and wound care	sheetStaff are to notify					
	the Nurse and Se	ervice Coordinator if any					
	redness, opening	s, or bleeding is					
	observed"						
	Client A's Skin	Assessment sheets from					
	1/13 to 1/16/13 i	ndicated the facility staff					
		at the above mentioned					
		s right leg on the skin					
		ts, and/or report the area					
		1 1/16/13 when it was					
		s attention. Further					
	_	ent daily skin assessment					
		staff did not conduct					
	and/or document						
		ents on 1/7, 1/8, 1/9, 1/13,					
	1/14, 1/15 and 1/	10/13.					
	Interview with a	taff #2 on 1/16/13 at 5:45					
		ent A did not have any					
	_	f #2 indicated facility					
		cument any open areas on					
		ent sheets. Staff #2					
		sessments/checks were					
	_	ient A and the completed					
	sheets were sent	to the nurse daily.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet Page 11 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G313	B. WIN			01/25/2013
NAME OF B	DOLUDED OD GUDDU IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			19038 N	MISSISSIPPI ST	
ARC OF NORTHWEST INDIANA INC, THE		·			N, IN 46341	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE
		PN #2 on 1/17/13 at 3:20				
		e was not aware of any				
		until she was called to				
	the group home	to assess the client on				
	1/17/13. LPN #2	2 indicated facility staff				
	were to complete	e daily skin checks on				
	client A and doc	ument any areas they				
	found. LPN #2 i	indicated daily skin				
	assessment sheet	ts were reviewed by the				
	nurse daily. LPN	N #2 indicated she was				
	covering for the nurse, for the group					
		id not know where the				
		3, 1/14, 1/15 and 1/16/13				
		sheets were located if				
	completed.	sheets were recated if				
	completed.					
	2. During the 1/	16/13 observation				
	between 5:14 PN	A and 6:20 PM, at the				
	group home, clie	ent A ate a regular diet as				
		id food at the dinner				
		consisted of beef rice and				
		f #1 placed the food on				
	_	Staff #1 did not offer the				
		et at the dinner meal.				
	chent a riquid div	et at the diffici mear.				
	Client A's 1/2013	3 Medication				
	Administration I	Record Book was				
	reviewed on 1/10	6/13 at 5:19 PM. A				
	1/6/13 Medication					
		medication (Compazine				
		ree times a day as				
	_	n ordered to start for				
	· /					
		and vomiting. The				
	1/16/13 medicati	ion Change Form				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet Page 12 of 13

	OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/25/2013
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	indicated "Continue clear liquids until [client A] has been free from vomiting and diarrhea for 24 hours. He may also return to workshop when free of vomiting & (and) diarrhea for 24 hours." Client A's record was reviewed on 1/17/13 at 2:35 PM. Client A's 1/16/13 Cumulative Medical Record indicated "Update from staff- [Client A] had diarrhea in the A.M. Immodium (diarrhea) given. One small bout after that. Ate lunch, will con't (continue) clear liquids-afebrile (no fever)." Interview with LPN #1 on 1/17/13 at 3:20 PM indicated client A should have received a clear liquid diet on 1/16/13. This federal tag relates to complaint #IN00119881. This deficiency was cited on 12/14/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PSZ212

Facility ID: 000832

If continuation sheet

Page 13 of 13